



**MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH
CLIENT REGISTRATION FORM**

LABEL

Please complete the form, with parent or primary caregiver information for minors. The following information is for the purpose of registration only and will be kept confidential. We appreciate your assistance.

May we mail reminders and contact you at home? (Confidential) ☐ YES ☐ NO Leave Message on home phone ☐ YES ☐ NO

Patient Information: (Please print clearly or circle appropriately)

NAME _____ **Date Of Birth** _____ **Birth Country** _____
(Last) (First) (Middle) (Month/Day/Year)

Have you ever used a different last or first name (circle one) Yes No If yes, Name used _____

Guardian or Parent Name (if younger than 18 years old) (Not Required for Clinic 6) _____

Marital Status Single Married Divorced Widowed Other **Gender:** ☐ Male ☐ Female ☐ _____ **Occupation** _____

Address _____ **Apt. #** _____ **City** _____ **State** _____

Zip _____ **County** _____ **Tel. # (home/message)** _____ **Tel # (work/cell)** _____

Name of the person to contact if needed (outside your home)

Name _____ **Relationship to patient** _____

Address: _____ **Apartment #** _____ **City** _____ **State** _____ **Zip code** _____

Telephone Number: _____ **Can we leave message/information** Yes No _____

Ethnicity/Race (Check only ONE)

Primary Language (Check only ONE)

- ☐ Hispanic or Latino
- ☐ White/Caucasian
- ☐ Black or African American
- ☐ American Indian
- ☐ Native Hawaiian
- ☐ Alaskan Native
- ☐ Asian or other Pacific Islander (must specify) _____
- ☐ Other (must specify) _____

- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ Burmese
- ☐ Somali
- ☐ Vietnamese
- ☐ Chinese
- ☐ Other (must specify): _____

Do you have insurance that covers primary medical care? (Your visits to the doctor) ☐ Yes ☐ No

Name of the Referring Physician/Clinic _____ **Telephone #** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Name of the Primary Care Provider/Clinic _____ **Telephone #** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

I hereby certify that all of the information given is correct.

Client/Guardian/Parent Signature _____ **Date** _____

FOR STAFF USE ONLY

Client PID: _____ **Date of Last Visit:** _____

Entered By: _____ **Staff Initials** _____ **Date** ____/____/____